Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $8,519.12 for date of service 10/03/01.
   b. The request was received on 01/29/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 01/03/02
   b. HCFA(s)
   c. TWCC 62 forms
   d. Medical Records
   e. EOBs from other carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. Response to a Request for Dispute Resolution dated 07/03/02.
   b. Reimbursement data
   c. SOAH Decisions
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/21/02. The response from the insurance carrier was received in the Division on 07/03/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

   a. The Requestor asserts that charges were for facility fees not professional fees. The payment received only represents 21% of the total billed amount. Other workers' compensation carriers reimburse at 85-100%. Additional reimbursement is sought in the amount of $8,519.12 for the date of service 10/03/01.

2. Respondent: letter dated 07/03/02

   a. "Provider has burden of proof in this case. The **only** evidence offered by Provider are EOBs from several other carriers. The State Office of Administrative Hearings has specifically rejected the use of EOBs to establish compliance with the Act's statutory reimbursement standards. The Provider has simply not met its burden of proof under 133.305(e)(1)(F) to establish that its billed charges of **$10,755.12** meet the statutory standards under the Act."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/03/01.

2. The provider billed $10,755.12 for date of service 10/03/01.

3. The carrier paid $2,236.00 for date of service 10/03/01.

4. The amount in dispute is $8,519.12 for date of service 10/03/01.

5. The carrier denies additional reimbursement on the submitted EOB as "360-ALLOWANCE FOR THIS PROCEDURE WAS MADE AT THE "FAIR AND REASONABLE" AMOUNT FOR THIS GEOGRAPHICAL AREA. M-REDUCED TO FAIR AND REASONABLE."

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable.
The provider has submitted reimbursement data. The provider has submitted EOBs from other carriers that have the same ICD-9 code as the date of service in dispute. These EOBs indicate that the provider has received reimbursement from 90% to 100% of the billed amount.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine what would be fair and reasonable reimbursement for the services provided. The carrier has submitted reimbursement data to explain how it arrived at what it considers fair and reasonable reimbursement and that meets the requirements of Rule 133.304. The provider has submitted EOBs from other carriers in an effort to document fair and reasonable reimbursement. Regardless of the carrier's methodology or response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted EOB(s) from other carriers that indicates those carriers paid 90% to 100% of the billed charges. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code.

The provider's documentation fails to justify or demonstrate that the fees requested are fair and reasonable. Therefore, no further reimbursement is recommended.

The above Findings and Decision are hereby issued this 6th day of August 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb